absolute total care
Healthy Connections

Medical Record Documentation Standards

	STANDARD DESCRIPTION
1	The medical record contains: patient's name, Medicaid ID # and date of birth.
2	Personal/biographical data includes address, employer, home and work telephone numbers, marital status, sex, age, responsible party (parent or guardian), as well as assessment of cultural and/or linguistic needs and physical impairments.
3	All entries in the medical record contain author identification, which may be a handwritten signature, unique electronic identifier or initials. (If more than one person documents in the medical record, there must be a record on file as to what signature is represented by which initials).
4	All entries have purpose of visit, are dated and service site is indicated.
5	The record is legible to someone other than the writer or in ink/electronic.
6	Significant illnesses and medical conditions are documented.
7	Medication allergies and adverse reactions are prominently noted in the record. If the patient has no known allergies or history of adverse reactions, this is appropriately noted in the record, NKA or NKDA.
8	Medication List includes drug administered or dispensed, instructions to member regarding dosage, initial date of prescription, and number of refills.
9	Past medical history (for patients seen three or more times) is easily identified and include any serious accidents, surgeries, and/or illnesses, discharge summaries, after-hours encounters, and ED encounters and follow up. For pediatric records (under 19 y/o) documentation of immunization status, past medical history relates to prenatal care, birth, operations, and childhood illnesses and a complete History and Physical (H&P).
10	For patients 10 years and over, there are appropriate notations concerning use of tobacco, alcohol, and substance abuse (for patients seen three or more times substance abuse history should be queried).
11	Appropriate subjective and objective information pertinent to the member's presenting complaint is documented in the history and physical.
12	Laboratory and other studies are ordered as appropriate.
13	Working diagnoses are consistent with findings.
14	Treatment plan is consistent with diagnoses.
15	Encounter forms or notes have a notation, when indicated, regarding follow-up care, calls, or visits. The specific time of return is noted in weeks, months, or PRN.
16	Unresolved problems from previous office visits are addressed in subsequent visits.
17	No evidence of under and over utilization of consultants (evidence of appropriate use of consultants).
18	If a consultation or referral to a specialist is requested, there is a note from the consultant in the record.
19	Consultation, lab and imaging reports filed in the chart are initialed by the practitioner who ordered them to signify review. If the reports are presented electronically or by some other method, there is also representation of review by the ordering practitioner. Consultation and abnormal lab and imaging study results have an explicit notation in the record of follow-up plans.
20	No evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure (does the care appear to be medically appropriate?).
21	An immunization record has been initiated for children, or an appropriate history has been made in the medical record for adults.
22	Evidence that preventive screening and services are offered in accordance with the ATC's practice guidelines. Health teaching and/or counseling is documented.
23	Documentation of advance directives, if completed.
24	Documentation of failure to keep an appointment.
25	Signed/dated consent for procedure (if appropriate)